Patient name: _____ Date of birth: ___/__/___
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization

For patients: The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your health care provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	____	____	____
2. Are you taking any medication?	____	____	____
3. Do you have allergies to medications, food, or any vaccine?	____	____	____
4. Do you have any long-term health concerns?	____	____	____
5. Have you ever had a serious reaction after receiving a vaccination?	____	____	____
6. Do you have cancer, leukemia, AIDS, or any other immune system problem?	____	____	____
7. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	____	____	____
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	____	____	____
9. For women: Are you pregnant or breastfeeding or is there a chance you could become pregnant in the next three months?	____	____	____
10. Have you received any vaccinations in the past 4 weeks?	_____	____	____
11 For persons receiving influenza vaccine: were you ever paralyzed by Guillain-Barre Syndrome?	____	____	____
12 Have you ever fainted from having blood drawn or an injection?	____	____	____

Form completed by: _____ Date: _____

Comments: _____ **RN Initials** _____

Adapted from the Immunization Action Coalition • 1573 Selby Ave • St Paul, MN 55104 • (651) 647-9009 • www.immunize.org
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